MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD

2003 ALTERNATIVE CRITERIA APPLICATION FOR

AN INDIVIDUAL NECMA HOSPITAL REQUESTING

GEOGRAPHIC RECLASSIFICATION

EFFECTIVE FEDERAL FISCAL YEAR 2005

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PLEASE READ INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION

THIS APPLICATION MUST BE COMPLETED AND RECEIVED BY THE MGCRB BY

5:00 P.M. EST SEPTEMBER 2, 2003. FAILURE TO COMPLY WILL RESULT IN DISMISSAL.

I. HOSPITAL INFORMATION

1. NAME OF HOSPITAL: _____

2. MEDICARE PROVIDER NUMBER: _____

3. STREET ADDRESS: _____

_____

_____ ZIP CODE _____ - _____

4. MAILING ADDRESS AND CONTACT NAME AND TELEPHONE NUMBER FOR ALL COMMUNICATIONS REGARDING THE APPLICATION:

(Organization) _____

(Person) _____

(Address) _____

_____

_____ ZIP CODE _____ - _____

(Telephone Number) _____

II. RECLASSIFICATION REQUEST

5. SEEKS RECLASSIFICATION FROM: _____
(INDICATE THE NAME AND IDENTIFICATION NUMBER (SEE TAB 1).)

SEEKS RECLASSIFICATION TO: _____
(INDICATE THE NAME AND IDENTIFICATION NUMBER (SEE TAB 1).)

III. GENERAL INFORMATION

6. A. IS THE HOSPITAL ALREADY RECLASSIFIED FOR FFY 2005 FOR THE WAGE INDEX UNDER A 3-YEAR WAGE INDEX RECLASSIFICATION?

YES _____ NO _____

B. IF "YES" to 6.A., WHAT RURAL OR URBAN AREA IS THE HOSPITAL RECLASSIFIED TO UNDER THE 3-YEAR WAGE INDEX RECLASSIFICATION?

_____

(SHOW THE NAME AND IDENTIFICATION NUMBER (SEE TAB 1) FOR THE STATE, MSA OR NECMA.)

7. A. IF THE HOSPITAL WAS RECLASSIFIED FOR THE WAGE INDEX VALUE FOR FFYs 2003 THROUGH 2005 (PURSUANT TO A 2001 APPLICATION) OR FOR FFYs 2004 THROUGH 2006 (PURSUANT TO A 2002 APPLICATION), DID THE HOSPITAL "WITHDRAW" OR "TERMINATE" SUCH RECLASSIFICATION?

YES _____ NO _____

B. IF THE ANSWER TO 7.A. IS "YES," DID THE HOSPITAL APPLY TO CANCEL A BOARD APPROVED "WITHDRAWAL" OR "TERMINATION"?

YES _____ NO _____

8. A. IS THE HOSPITAL ALSO A MEMBER OF A GROUP RECLASSIFICATION REQUEST?

YES _____ NO _____

B. IF "YES" TO 8.A., ENTER THE NAME OF THE COUNTY OR NECMA IN WHICH THE GROUP IS LOCATED:

_____

C. IS THE HOSPITAL ALSO A MEMBER OF A STATEWIDE WAGE INDEX AREA REQUEST?

YES _____ NO _____

GENERALLY, THE BOARD WILL RULE ON ANY STATEWIDE WAGE INDEX APPLICATION FIRST, AND THEN THE GROUP APPLICATION BEFORE IT REVIEWS THE INDIVIDUAL REQUEST.

9. A. IS THE HOSPITAL AN URBAN HOSPITAL APPLYING TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) REGIONAL OFFICE TO BE TREATED AS BEING IN A RURAL AREA? (42 C.F.R. § 412.103; REFER TO THE INSTRUCTIONS FOR FURTHER INFORMATION.)

YES _____ NO _____

B. IF "YES" TO 9.A., HAS THE HOSPITAL'S APPLICATION BEEN APPROVED?

YES _____ NO _____

IF "YES" TO 9.B., ATTACH A COPY OF THE APPROVAL LETTER UNDER **ATTACHMENT A**.

10. INDICATE WHETHER THE HOSPITAL IS REQUESTING AN ORAL HEARING:

YES _____ NO _____

ATTACH RATIONALE FOR REQUEST UNDER **ATTACHMENT B?**

11. INDICATE PRIOR YEAR CASE NUMBER (S):

99_____ 00_____ 01_____ 04_____

IV. ALTERNATIVE CRITERIA FOR HOSPITALS LOCATED IN A NECMA

12. CAN THE HOSPITAL DEMONSTRATE THAT IT WOULD HAVE BEEN DESIGNATED TO THE REQUESTED URBAN AREA UNDER THE CRITERIA FOR DESIGNATING MSAs IN NEW ENGLAND?

YES _____ NO _____

IF YES, ATTACH SUPPORTING DATA FROM THE OMB LISTING UNDER ATTACHMENT **C**.

AFFIDAVIT

COUNTY OF_____

STATE OF_____

I, _____ (TYPE OR PRINT NAME), BEING DULY SWORN, DEPOSE AND SAY AS FOLLOWS:

(1) I CERTIFY THAT I HAVE EXAMINED THE ACCOMPANYING APPLICATION FOR GEOGRAPHIC RECLASSIFICATION AND ALL OF THE SUPPORTING INFORMATION AND DATA INCLUDED IN THE SUBMITTAL BY _____ _____ (HOSPITAL NAME AND MEDICARE PROVIDER NUMBER) THAT IS DUE TO THE MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD NO LATER THAN SEPTEMBER 2, 2003. I HEREBY DECLARE UNDER PENALTY OF PERJURY (28 U.S.C. SECTION 1746) THAT THE FOREGOING IS TRUE AND CORRECT.

(2) I UNDERSTAND THAT AN OMISSION, MISSTATEMENT, MISREPRESENTATION, OR ERROR MADE IN A HOSPITAL'S APPLICATION AND SUPPORTING INFORMATION AND DATA FOR GEOGRAPHIC RECLASSIFICATION MAY BE GROUNDS FOR DENIAL OF THE HOSPITAL'S APPLICATION.

(3) I UNDERSTAND THAT AN OMISSION, MISSTATEMENT, MISREPRESENTATION, OR ERROR MADE IN A HOSPITAL'S APPLICATION AND SUPPORTING INFORMATION AND DATA FOR GEOGRAPHIC RECLASSIFICATION MAY BE CAUSE FOR LEGAL ACTION AGAINST THE APPLICANT HOSPITAL AND ITS OFFICIALS.

(4) I CERTIFY THAT I AM AN OFFICER OF THE HOSPITAL NAMED IN (1) ABOVE OR A CORPORATE OFFICER OF THE HOSPITAL'S PARENT CORPORATION WITH AUTHORITY TO SIGN THE APPLICATION FOR GEOGRAPHIC RECLASSIFICATION ON BEHALF OF THE HOSPITAL.

SIGNATURE:_____

TITLE: _____

PHONE NUMBER: _____

SUBSCRIBED AND SWORN BEFORE ME
THIS _____ DAY OF _____2003
(DAY) (MONTH)

_____
(SIGNATURE OF NOTARY)

NOTARY PUBLIC
MY COMMISSION EXPIRES: _____